DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION

GRANT APPLICATION

REGIONAL MEDICAL PROGRAM

TO BE COMPLETED BY APPLICANT

1. TITLE OF PROJECT (OR PROGRAM) *(Limit to 53 spaces)*

2. NAME AND ADDRESS OF APPLICANT *(Street Number, Street Name, City, County, State or Country, ZIP Code)*

CONG. DISTRICT

3. EMPLOYER'S IDENTIFICATION NUMBER

4. DIRECTOR OF PROJECT *(Program or Center Director, Coordinator or Principal Investigator)*
NAME *(Last, First, Middle Initial)*
☐ Mr.
☐ Miss
☐ Mrs.
☐ _____
(Specify)

TITLE

DEGREE | SOCIAL SECURITY NUMBER

ADDRESS *(Street Number (or Box Number), Street Name, City, State (or Country), ZIP Code)*

OFFICE TELEPHONE *(Area Code, Tel. No., Extension)*

5. PROJECT PERIOD (TRIENNIUM)

FROM *(Mo., Day, Yr.)* | THROUGH *(Mo., Day, Yr.)*

6. BUDGET PERIOD

FROM *(Mo., Day, Yr.)* | THROUGH *(Mo. Day, Yr.)*

7. AMOUNT REQUESTED FOR

a. BUDGET PERIOD $_____
(Include Indirect Costs)

8. FINANCIAL MANAGEMENT OFFICIAL
NAME *(Last, First, Middle Initial)*
☐ Mr.
☐ Miss
☐ Mrs.
☐ _____
(Specify)

TITLE

ADDRESS *(Street Number (or Box Number), Street Name, City, State (or Country), ZIP Code)*

OFFICE TELEPHONE *(Area Code, Tel. No., Extension)*

ASSURANCES AND CERTIFICATIONS BY APPLICANT

The following assurances and certifications are part of the project grant application and must be signed by an official duly authorized to commit and assure that the applicant will comply with the provisions of the applicable laws, regulations, and policies relating to the project.

The applicant hereby assures and certifies that he has read and will comply with the following:

Title VI—Civil Rights Act of 1964 (PL 88-352) and Part 80 of Title 45, Code of Federal Regulations, so that no person will be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination on the grounds of race, color, or national origin.

Patents and inventions (Current PHS Policy Statement) under which all inventions made in the course of or under any grant shall be promptly and fully reported to HEW.

Specific assurances, policies, guidelines, regulations and requirements in effect at the time the grant award is made and applicable to this project (including the making of reports as required and the maintenance of necessary records and accounts, which will be made available to the Department of HEW for audit purposes) which are contained and listed in the grant application package and made a part hereof.

SIGNATURES - Use Ink. *Autographic signature of Official authorized to sign for applicant and Project Director or other person(s) authorized to sign in their behalf.*

APPLICANT NO. 1 *(Name only)*

DIRECTOR OF PROJECT	*(Signature only)*	DATE *(Mo., Day, Yr.)*
OFFICIAL AUTHORIZED TO SIGN FOR APPLICANT	SIGNATURE	DATE *(Mo., Day, Yr.)*
	NAME *(First, middle initial, last)* AND TITLE ☐ MR. ☐ MRS. ☐ MISS ☐ _____ *(Specify)*	DEGREE
COMPLETE FOR RMPS ONLY	SIGNATURE OF CHAIRMAN OF ADVISORY GROUP	DATE *(Mo, Day, Yr.)*

ORGANIZATION AND PERFORMANCE SITE DATA
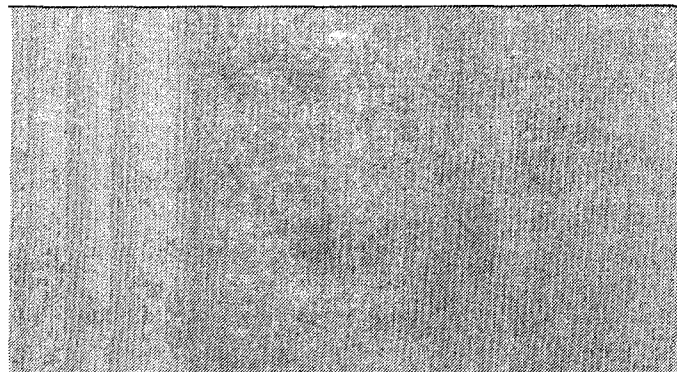
PROJECT IDENTIFICATION NUMBER

1. APPLICANT *(Name only)*
ORGANIZATIONAL LEVEL - 1

ORGANIZATIONAL LEVEL - 2

ORGANIZATIONAL LEVEL - 3

ORGANIZATIONAL LEVEL - 4

ORGANIZATIONAL LEVEL - 5

REGION _____

☐ CORE

☐ DEVELOPMENT COMPONENT

☐ OPERATIONAL ACTIVITY NO. _____ (9-12)

| RMP NO. (1-2) | DATE | | PAGE (7-8) |
	MO. (3-4)	YR. (5-6)	
			0 3

7. ARE FEDERAL FACILITIES TO BE USED FOR THIS PROJECT? (13)

₁☐ NO   ₂ ☐ YES _____ (14-16) % of time

8. ORGANIZATION DESCRIPTORS

A. TYPE

(1) PUBLIC

(17)☐ Federal   (22) ☐ County
(18)☐ State   (23) ☐ City
(19)☐ Interstate   (24) ☐ School District
(20)☐ Metropolitan (25) ☐ Special Unit
(21)☐ Other *(specify)* _____

(2) PUBLIC SPONSORED

(26) ☐ Community Action
(27) ☐ Sponsored Organization
(28) ☐ Other *(specify)*

(3) PRIVATE NONPROFIT
Indicate the type of proof of NON-PROFIT STATUS furnished:

(a) IRS Cumulative List Reference

Submitted*

(b) IRS Tax Exemption Certificate   (29) ☐
(c) State Certificate Statement   (30) ☐
(d) Certificate of Incorporation   (31) ☐
(e) Statement of Affiliation with Parent Organization   (32) ☐

*Indicate the Place and Date filed:

4. MODEL CITY INVOLVEMENT
_____ % (33-35)

5. INVENTIONS *(Complete for continuation applications only)* (36)

A. ☐ NO

B. ☐ YES - NOT PREVIOUSLY REPORTED

C. ☐ YES - PREVIOUSLY REPORTED

B. FUNCTION

(37) ☐ Educational
(38) ☐·Other *(specify)*

(39) ☐ Planning
(40) ☐ Service

(41) ☐ Hospital

6. HUMAN SUBJECTS AT RISK (42) ☐ Yes ☐ No *(see instructions)*
                                    1   2

CERTIFICATION ☐ Yes - Approved *(Date)* _____
               ☐ Yes - Pending Review *(Date)* _____

SPECIAL ASSURANCE *(certification attached?)* ☐

9. GEOGRAPHIC SCOPE

(43) ☐ National   (45) ☐ Statewide   (47) ☐ Local
(44) ☐ Regional   (46) ☐ Areawide   (48) ☐ Other *(specify)*

10. PERFORMANCE SITE(S): The places where the project will be concluded; (49)

A. ☐ AT APPLICANT ADDRESS ONLY
B. ☐ AT APPLICANT ADDRESS AND OTHER SITES
C. ☐ AT OTHER SITES ONLY
IF "B" OR "C", IDENTIFY OTHER SITES BELOW.

SITE NO. _____ *(Name)*

ADDRESS *(Street Number, Street Name, City, County, State or Country)*

CONG. DISTRICT

SITE NO. _____ *(Name)*

ADDRESS *(Street Number, Street Name, City, County, State or Country)*

CONG. DISTRICT

SITE NO. _____ *(Name)*

ADDRESS *(Street Number, Street Name, City, County, State or Country)*

CONG. DISTRICT

SITE NO. _____ *(Name)*

ADDRESS *(Street Number, Street Name, City, County, State or Country)*

CONG. DISTRICT

ORGANIZATION AND PERFORMANCE SITE DATA—Continued

PERFORMANCE SITE(S)—The places where work will be performed

SITE NO. _____ (name)

ADDRESS *(Street Number, Street Name, City, County, State or Country)*

CONG. DISTRICT

SITE NO. _____ (name)

ADDRESS *(Street Number, Street Name, City, County, State or Country)*

CONG. DISTRICT

SITE NO. _____ (name)

ADDRESS *(Street Number, Street Name, City, County, State or Country)*

CONG. DISTRICT

SITE NO. _____ (name)

ADDRESS *(Street Number, Street Name, City, County, State or Country)*

CONG. DISTRICT

SITE NO. _____ (name)

ADDRESS *(Street Number, Street Name, City, County, State or Country)*

CONG. DISTRICT

SITE NO. _____ (name)

ADDRESS *(Street Number, Street Name, City, County, State or Country)*

CONG. DISTRICT

SITE NO. _____ (name)

ADDRESS *(Street Number, Street Name, City, County, State or Country)*

CONG. DISTRICT

SITE NO. _____ (name)

ADDRESS *(Street Number, Street Name, City, County, State or Country)*

CONG. DISTRICT

SITE NO. _____ (name)

ADDRESS *(Street Number, Street Name, City, County, State or Country)*

CONG. DISTRICT

SITE NO. _____ (name)

ADDRESS *(Street Number, Street Name, City, County, State or Country)*

CONG. DISTRICT

SITE NO. _____ (name)

ADDRESS *(Street Number, Street Name, City, County, State or Country)*

CONG. DISTRICT

SITE NO. _____ (name)

ADDRESS *(Street Number, Street Name, City, County, State or Country)*

CONG. DISTRICT

(1) NAME AND ADDRESS	(2) INSTITUTION AND/OR OCCUPATION			(3) CATEGORIES OF REPRESENTATION		(4) CHECK IF ON STEERING/ EXEC. COMM.
		9	10		11	12
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐

LIST OF MEMBERS OF THE REGIONAL ADVISORY GROUP AND STEERING OR EXECUTIVE COMMITTEE

RMP

RMP NO. (1-2)	DATE MO. (3-4)	YR. (5-6)	PAGE (7-8)
			0 4

HRA-T4 (Formerly RMP-34-1) (Page 4)

RAG BOARDS/COMMITTEES AND RMP LOCAL ADVISORY GROUPS

RMP		RMP NO. (1-2)	DATE MO. (3-4)	YR. (4-5)	PAGE (7-8)
					0|5

NAME OF COMMITTEE OR GROUP	TYPE (Check one)		NO. MEMBERS		NO MTGS. LAST YEAR	FUNCTIONS AND RESPONSIBILITIES
	Stand-ing	AD-HOC	TOTAL	MINORITY		
(9-11)	(12) □ 1	□ 2	(13-15)	(16-18)	(19-21)	
(9-11)	(12) □ 1	□ 2	(13-15)	(16-18)	(19-21)	
(9-11)	(12) □ 1	□ 2	(13-15)	(16-18)	(19-21)	
(9-11)	(12) □ 1	□ 2	(13-15)	(16-18)	(19-21)	
(9-11)	(12) □ 1	□ 2	(13-15)	(16-18)	(19-21)	
(9-11)	(12) □ 1	□ 2	(13-15)	(16-18)	(19-21)	
(9-11)	(12) □ 1	□ 2	(13-15)	(16-18)	(19-21)	

				RMP	RMP NO. (1-2)	DATE MO YR (3-4) (5-6)	PAGE (7-8) 0,6

IDENT. NO. (9-11)	RMP JOB OR POSITION TITLE* (12-31)	NAME AND DEGREE	DISCIPLINE PROFESSIONAL OR OTHER SPECIALTY	INSTITUTIONAL AFFILIATION**	% TIME OR EFFORT (32-34)	RMP SALARY *** (35-39)

HRA-T4 (Formerly RMP-34-1) (page 6) 2-74   *If position not filled write vacancy.   **Show particular school where appropriate.   ***If fringe benefits are not included, show total fringe benefits on separate line.

	CORE STAFF *				PROJECT STAFF				PLANNING AND ADVISORY GROUPS AND COMMITTEES			
	Professional and Technical (9) [1]		Secretarial Clerical (9) [2]		Professional and Technical (9) [3]		Secretarial Clerical (9) [4]		Regional Advisory Group (9) [5]		Other (9) [6]	
	No.	FTE **	No.	FTE **	No.	FTE **	No.	FTE **	No.	FTE **	No.	FTE **
TAL STAFF OR)VISORY GROUP :MBERS												
MALE	(10-14)	(15-19)	(10-14)	(15-19)	(10-14)	(15-19)	(10-14)	(15-19)	(10-14)	(15-19)	(10-14)	(15-19)
FEMALE	(20-24)	(25-29)	(20-24)	(25-29)	(20-24)	(25-29)	(20-24)	(25-29)	(20-24)	(25-29)	(20-24)	(25-29)
)TAL MINORITY ROUP STAFF OR)VISORY GROUP MEMBERS												
BLACKS ***	(30-34)	(35-39)	(30-34)	(35-39)	(30-34)	(35-39)	(30-34)	(35-39)	(30-34)	(35-39)	(30-34)	(35-39)
AMERICAN INDIANS ***	(40-44)	(45-49)	(40-44)	(45-49)	(40-44)	(45-49)	(40-44)	(45-49)	(40-44)	(45-49)	(40-44)	(45-49)
SPANISH SURNAMES ***	(50-54)	(55-59)	(50-54)	(55-59)	(50-54)	(55-59)	(50-54)	(55-59)	(50-54)	(55-59)	(50-54)	(55-59)
ORIENTAL ***	(60-64)	(65-69)	(60-64)	(65-69)	(60-64)	(65-69)	(60-64)	(65-69)	(60-64)	(65-69)	(60-64)	(65-69)
OTHER MINORITY GROUPS (Specify)	(70-74)	(75-79)	(70-74)	(75-79)	(70-74)	(75-79)	(70-74)	(75-79)	(70-74)	(75-79)	(70-74)	(75-79)

*The total of "Professional and Technical" and "Secretarial and Clerical" personnel should equal the number
  of positions shown on Page 6 "RMP Job or Position Title" column less any vacancies.
**Give best estimate of full time equivalent (FTE).
***Give best estimate where records are not maintained.

DISCRETE ACTIVITY SUMMARY

RMP		RMP NO. (1-2)	DATE		PAGE (7-8)
			MO. (3-4)	YR. (5-6)	
					1|5

1. TITLE		2. IDENT. NUMBER (9-12)	3. DATE OF INITIAL RMPS SUPPORT	
			MONTH (13-14)	YEAR (15-16)

4. SPONSOR *(Institution/Organization)*	5. GEOGRAPHIC AREA SERVED (17-18)	6. EST. TERMINATION DATE OF RMPS SUPPORT	
		MO. (19-20)	YEAR (21-22)

7. DIRECTOR

9. TARGET GROUP(S) (25-28)

8. PRIMARY ACTIVITY AND DISEASE EMPHASIS (23-24)

A. CONSUMERS AND/OR PATIENTS

B. PROVIDERS (29-30)

10. SIGNIFICANT RELATIONSHIPS WITH OTHER FEDERAL PROGRAMS *(Check all applicable)*

(31) A ☐ OEO
(32) B ☐ EXP. HEALTH PLAN. & DELIV.
(33) C ☐ HEALTH RESEARCH

(34) D ☐ CHP-A
(35) E ☐ CHP-B
(36) F ☐ CHP-C
(37) G ☐ CHP-E

(38) H ☐ MOD. CITIES
(39) I ☐ HMO
(40) J ☐ FDA
(41) K ☐ APPALACHIA

(42) L ☐ NIH-INSTITUTES
(43) M ☐ HEALTH MANPOWER
(44) N ☐ OTHER *(Specify)*

11. PROPOSAL	PERIOD				12. PROGRESS	PERIOD			
	FROM (45-48) MO.	YR.	THROUGH (49-52) MO.	YR.		FROM (53-56) MO.	YR.	THROUGH (57-60) MO.	YR.

$_____

A. WHAT ARE THE GENERAL OBJECTIVES?
B. WHAT SPECIFIC ACTIVITIES WILL BE UNDERTAKEN DURING THE ABOVE PERIOD?
C. WHAT RESOURCES WILL BE EMPLOYED?
D. WHAT SPECIFIC OUTPUTS ARE PLANNED FOR THE ABOVE PERIOD?

A. WHAT SPECIFIC ACTIVITIES WERE UNDERTAKEN?
B. WHAT WERE THE RESULTANT OUTPUTS?
C. WHAT SIGNIFICANT BENEFITS OR FINDINGS HAVE OCCURRED TO DATE?
D. WHAT PROBLEMS, IF ANY WERE ENCOUNTERED?
E. IF RMP SUPPORT HAS BEEN OR WILL BE TERMINATED, EXPLAIN (1) WHY? (2) WHETHER THE ACTIVITIES WILL BE CONTINUED WITH OTHER SUPPORT AND, IF SO, (3) THE LEVEL OF SUPPORT.

FINANCIAL DATA RECORD

RMP NO. (1-2)	COMPON-ENT IDENT. (3-6)	F.Y. (7-8)	ACTION DATE mo. (9-10) yr. (11-12)

(13) ACTION CODES

1 ☐ REQUEST
2 ☐ EXPENDITURE
3 ☐ REBUDGET

FOR DRMP USE ONLY
4 ☐ AMENDED AWARD
5 ☐ AWARD

(14) SUPPORT CODES (check one)

1 ☐ New, not previously approved
2 ☐ Continuation beyond approved period of support
3 ☐ Termination
4 ☐ Approved, not previously initiated
5 ☐ Continuation within approved period of support

SUPP YR (13-15)

CARD 1

SPONSOR (INSTITUTION/ORGANIZATION) (18-67)

REGION NAME:

RMP_____

CARD 2

COMPONENT TITLE (Use only significant words) (18-67)

COMP SUPP. YEAR (68-69)

CARD 3

COORDINATOR/PROJECT DIRECTOR
(Last Name, First Name, Initial) (18-47)

	BUDGET PERIOD				TERMINATION DATE				FOR DRMP USE ONLY			
	FROM		THRU		ESTIMATED		ACTUAL		CASE CODE	ST.	CNTY	CITY
	mo. (48-49)	yr. (50-51)	mo. (52-53)	yr. (54-55)	mo. (56-57)	yr. (58-59)	mo. (60-61)	yr. (62-63)	(64-70)	(71-72)	(73-75)	(76-79)

CARD 4

PERSONAL SERVICES		PATIENT CARE		EQUIPMENT		CONSTRUCTION	
SALARY/WAGES (18-24)	EMPLOYEE BENEFITS (25-31)	INPATIENT (32-38)	OUTPATIENT (39-45)	BUILT-IN (46-52)	MOVABLE (53-59)	NEW (60-66)	MAJOR ALT. & RENOVATIONS (67-73)

CARD 5

CONSULTANT COSTS (18-24)	SUPPLIES (25-31)	TRAVEL		RENT		MINOR ALT. & RENOVATIONS (60-66)	PUBLICATION COSTS (67-73)	CONTRACTUAL SERVICES (74-80)
		DOMESTIC (32-38)	FOREIGN (39-45)	SPACE (46-52)	OTHER (53-59)			

CARD 6

COMMUNICA-TION COSTS (18-24)	COMPUTER & DATA PROCESSING (25-31)	OTHER (32-38)	TRAINEE COSTS		DIRECT ASSISTANCE			
			STIPENDS (39-45)	OTHER (46-52)	PERSONAL SERV. (53-59)	EQUIPMENT (60-66)	SUPPLIES (67-73)	OTHER (74-80)

CARD 7

DIR. COSTS AUTH. (EXPENDITURE REPORTS ONLY) (18-24)	DRMP DIRECT COSTS THIS BUDGET PERIOD (25-31)	INDIRECT COSTS THIS BUDGET PERIOD							DRMP SUPPORT (DIRECT COSTS ONLY)				
		TOTAL (32-38)	% RATE (39-43)	BASE (44-50)	CODE 51	% RATE (52-56)	BASE (57-63)	CODE 64	ADDITIONAL BUDGET PERIOD (65-71)	CODE 72	ADDITIONAL BUDGET PERIOD (73-79)	CODE 80

INDIRECT COST CODES FOR CARD 7 (51 AND 64)

1. Salary and wages only.
2. Total Allowable Direct Costs.

CARD 8

GRANT RELATED INCOME		STATE FUNDS (32-38)	LOCAL FUNDS (39-45)	OTHER FEDERAL FUNDS (46-52)	OTHER NON-FEDERAL FUNDS (53-59)	TOTAL DIRECT ASSISTANCE (Not Direct Cost) (60-66)	TOTAL FUNDS THIS PERIOD (All Sources) (67-73)
INTEREST (18-24)	OTHER (25-31)						